HEALTH SYSTEMS DIVISION
Licensing and Certification
Kate Brown, Governor

Oregon Health Authority

500 Summer Street NE, E-86
Salem, OR 97301-1118
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www.oregon.gov/dhs/mentalhealth

CERTIFICATION APPLICATION
BEHAVIORAL HEALTH TREATMENT SERVICES; INVOLUNTARY COMMITMENT PROCEEDINGS

SECTION I: INSTRUCTIONS

- Please complete this application in full, incomplete applications may require resubmission.
- Remember to **sign** and **date** the Attestation of Compliance, found in Section V.
- Attach all required documents **in the order as outlined in section VI**.

Send to: Terry Schroeder
Oregon Health Authority,

Health Systems Division
Licensing and Certification Unit
500 Summer Street, NE, E86
Salem, OR 97301

or **Email to** Terry.Schroeder@dhsoha.state.or.us

PROCESS FOR APPLICATION REVIEW

1. Review and utilize the following Oregon Administrative Rules (OAR) governing Certification of Outpatient Behavioral Health Treatment Providers and Outpatient Addictions and Mental Health Services **prior to** beginning the application process:

   Outpatient Behavioral Health Treatment Providers
   OAR 309-008-0100 through OAR 309-008-1600
   http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_008.html

2. Timeframe of application submission OAR 309-008-0400(6). Applicants seeking initial certification must submit a completed application at least six months in advance of the applicant's desired date of certification; applicant seeking to renew a current certification must submit a complete application **at least six months prior to the expiration of the existing certificate**.

3. Within 60 days of receiving the complete application Health Systems Division (HSD) will complete a desk review of all submitted materials and may respond with questions, request additional information, request an onsite walkthrough, or request a resubmission of application materials, if incomplete.

4. When additional information is required to approve the application, the applicant must provide the requested information to HSD within 14 days of receipt of the request for additional information. If a new application, skip to number 6.

5. For renewal applications, prior to the expiration of the Certificate of Approval (COA), HSD will conduct an onsite review to determine the level of compliance with the applicable Oregon Administrative Rules.
6. For renewal applications, HSD will send a final report within 30 days after completion of the onsite review. The agency is required to submit a written Plan of Correction (POC) to HSD within 30 days of receiving the final report. The POC must show how the agency will resolve all areas of noncompliance with administrative standards.
7. Upon approval of this application, a COA will be issued to the agency for up to one year for new applications and 2 years for renewal applications.
8. Upon issuing a COA, HSD will contact the Background Check Unit (BCU) notifying them of the certification and sending them a copy of the COA.

SECTION II: APPLICANT INFORMATION
A. Name of Facility: Providence Portland Medical Center (PPMC) Providence St Vincent Medical Center (PSVMC) Providence Milwaukie Hospital (PMH) Providence Willamette Falls Hospital (PWFH)
B. Physical Address of Facility: PPMC: 4805 NE Glisan Street Portland, OR 97213 PSVMC: 9205 SW Barnes Road Portland, OR 97225 PMH: 10150 SE 32nd Avenue Portland, OR 97222 PWFH: 1500 Division St, Oregon City, OR 97045
C. Name and title of Facility Director: PPMC: Krista Farnham, CEO PSV: Jennifer Burrows, CEO PMH: Victor Carrasco, CEO PWFH: Brad Henry, CEO
D. Phone number of Facility Director: PPMC: (503) 215-1111 PSVMC (503) 216-1234 PMH: (503) 513-8300 PWFH: (503) 656- 1631
E. Name and title of Program Manager: PPMC ED: Jessica Monego PPMC IP: Amy Nist PSVMC ED: Phaedra Crane PSVMC IP: Shanna Branham PMH ED: Robert Evans PMH IP: Maria Brignola PWFH ED: Karen Jeffrey-Markowski
F. Phone number of Program Manager: PPMC: (503) 215-1111 PSVMC (503) 216-1234 PMH: (503) 513-8300 PWFH: (503) 656- 1631
G. Name and title of person preparing this application: Kristin Powers, Regional Director

H. Email address of person preparing this application: Kristin.powers@providence.org

I. Phone number of person preparing this application: (541) 306-7908

J. Complete physical address of the administrative office:
PPMC: 4805 NE Glisan Street Portland, OR 97213
PSVMC: 9205 SW Barnes Road Portland, OR 97225
PMH: 10150 SE 32nd Avenue Portland, OR 97222
PWFH: 1500 Division St, Oregon City, OR 97045

K. Complete mailing address of the administrative office:
Please see above

L. County where administrative address is located:
PPMC: Multnomah
PSV: Washington
PMH: Clackamas
PWFH: Clackamas

Main agency phone number: Please see above

M. Main agency fax number: n/a

N. Hospital ~~Agency~~ website: Providence-Oregon: A network of hospitals, care centers, health plans, physicians, clinics, home health care and affiliated services | Providence Oregon

O. Is the hospital ~~agency~~ contracted with a Coordinated Care Organization (CCO): Yes ☒ No ☐

P. Name of CCO (if applicable): HealthShare of Oregon

Q. All personnel responsible for administering the delivery of behavioral health services for the agency (as applicable please include such positions as the Medical Director, Program Director or Administrator, Psychiatrist, Psychiatric Consultant, License Medical Practitioner and Clinical Supervisor(s). For each personnel listed, include verification of their credentials relative to their position.

Name, Title	Credential	Phone	Email
Medical Director PPMC ED:Vincent Torres PPMC IP: Moses Ijaz PSVMC ED: Kenneth Bizovi PSVMC IP: Thomas Rittman PMH ED: Chad Byars PMH IP: Jeffrey Buenjemia PWFH ED: Joseph Campbell	 MD MD MD MD MD MD MD		
Quality Management Coordinator PPMC: Heather Han PSVMC: Raji Chandrasekaran PMH: Helen Linneman PWFH: Helen Linneman	 RN RN RN		
Regional Medical Director BH Operations	Brian Liebreich, MD	(503) 215-4860	Brian.liebreich@providence.org

Regional Program Director BH Integration &Acute Care	Kristin Powers, LCSW	(541)306-7908	Kristin.powers@providence.org
Regional Manager Professional Practice/Development/Systems/Quality Emergency Services	Angela Graves, MSN, RN, CEN, NE-BC		
RN Manager-Clinical Ops Emergency Services and IP Psych PPMC ED: Jessica Monego PPMC IP: Sarah Tarter PSVMC ED: Phaedra Crane PSVMC IP: Chris Hatch PMH ED: Robert Evans PMH IP: Brittany Caldera PWFH: Karen Jeffrey-Markowski	 RN RN RN RN RN RN RN		

R. Please list any action(s) taken on any certificate or license of person(s) identified in R above including denial, suspension, conditions, intent to revoke or revocation by the Division, Oregon Health Authority, Oregon Department of Human Services, or any other state agency or licensing board. Use a separate sheet if necessary.

Name of Owner/Director	Name of Certification or License	Issued/Expired Dates	Agency Name	Action Taken
n/a				

SECTION III: SERVICE DELIVERY RULES

Please review and select the applicable OAR program type that pertains to the Certificate for which you are requesting for your agency: ***Please note: The following services have specific Oregon Administrative Rules describing minimum standards for state approval. You will need to submit separate policies and procedures for each service listing you wish to be approved.***

☐ Regional Acute Care Psychiatric Services for Adults

✓ ☐ **Hospital Hold and Seclusion Room Services (5 day Hold)**

☐ Hospital Transport Custody Services (12 Hour Transport Custody)

☐ Class I Secure Residential Treatment Facility (Non-hospital facility) approved to be locked to prevent a person from leaving the facility, to use seclusion and restraint and to involuntarily administer psychiatric medication

☐ Class II Secure Residential Treatment Facility (Non-hospital facility) approved to be locked to prevent a person from leaving the facility

Please be advised that state approval does not automatically guarantee eligibility to participate as an OHP provider. To become an OHP (Medicaid) provider, please contact **HSD Provider Enrollment Unit** by phone 800-336-6016, email: provider.enrollment@state.or.us , or by visiting the provider enrollment webpage: http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx

SECTION IV – NEW APPLICATION QUESTIONAIRE **- please use a separate document to answer these questions and attach to the application -**
~~1. Description of facility, if applicable include the emergency department and number of hold rooms in the facility.~~
~~2. Description of services to be provided to individuals in custody, on diversion or under commitment.~~
~~3. If applicable, describe any agency agreements or partnerships pertaining to the transfer of individuals in custody for treatment.~~
~~4. Describe the program process for coordinating services with community mental health programs (CMHPs) including referral for services, and if applicable, notification of custodies, and coordination with courts.~~
~~5. Submit a copy of the training curriculum relating to the management of endangering behaviors including the proper use of seclusion and restraint, the correct application of restraint and seclusion devises used by the facility, and the use of non-physical intervention skills.~~

SECTION IV – RENEWAL APPLICATION QUESTIONAIRE **- please use a separate document to answer these questions and attach to the application -**
1. Describe any changes in administration positions relating to program management including, Program Director or Administrator, Medical Director (if applicable), License Medical Practitioner and Clinical Supervisor(s). **n/a**
2. Describe any physical facility changes to the psychiatric treatment unit, emergency department, hold rooms or common areas relative to patient safety and security. **n/a**
3. Describe any changes in policies and procedures relating to the care, custody and treatment of persons in custody, with a summary of what was changed since the last review. **Notice of Mental Illness Policy (please see attached). Update to LIP section.**
4. Describe any changes in training relating to managing individuals in crisis and the use of seclusion and restraint. **n/a**
5. If applicable, describe any changes or updates to existing memorandums of understanding (MOU) or contracts relating to individuals in custody or on a hold. **n/a**
6. Since the last site review, has the agency's professional liability insurance ever been terminated, denied renewal, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged)? **n/a**
7. Does the agency have any variances approved by HSD? Is yes, please include a copy of the current variance. If requesting a renewal of the variance, also include a new variance request form and an update on the condition or reasons as to why the variance continues to be needed. **Yes. Please see attached.**

SECTION V: ATTESTATION OF COMPLIANCE
Pursuant to requirements in the Oregon Administrative Rules and as the legal authority of (agency), by my signature below I attest to the following:
1. I am an authorized person representing the agency intentions and best interest of all board members, shareholders and/or owners;
2. The information provided on the application is valid and complete;
3. The agency will comply with the Oregon Administrative Rules that govern these services;
4. If applicable, the agency is in compliance with all other licensing or accreditation entities that apply, i.e., Department of Human Services, Drug Enforcement Administration (DEA), etc.;
5. The agency will maintain continuous liability insurance;
6. The agency is compliant with federal, state, and local regulations that govern individual privacy and confidentiality, including, but not limited to, HIPAA, and 42 CFR Part 2;
7. The agency will prioritize the assurance of individuals' health, safety, and welfare.
8. The agency will fulfill all mandatory reporting duties;
9. The agency is not employing personnel who have been convicted of any felony, or a misdemeanor associated with the provision of behavioral health services;
10. Agency staff will adhere to the agency code of conduct. In addition, agency staff will report suspected ethical violations (including impairment) to the responsible party and appropriate credentialing parties (such as certification boards, licensing entities, etc.);
11. The agency will notify HSD within 15 days of changes to the Medical or Executive Director by submission of qualifications of the new Director;
12. The agency will notify HSD, in writing, of office location changes or addition.
13. I understand that Certificates of Approval are not transferable to any other person, entity, provider, or non-Division approved service delivery location.

Kristin Powers, LCSW

	2/7/2022
Authorized Signature	Date
Kristin Powers, LCSW	
Printed Name/Title	

SECTION VI: SUBMISSION REQUIREMENTS
PART I: GENERAL REQUIREMENTS FOR ALL HOSPITALS AND NON-HOSPITAL FACILITIES
☒ State Application Form (pp. 2-5) (This application)
☒ Verification of liability insurance
☒ Organizational chart (Psychiatric treatment unit, Secure Residential Treatment Facility or Emergency Department)
☒ Submit documentation of the job description and qualifications of the Program Administrator, Medical Director, Program Psychiatrist or Psychiatric consultant or ILP and person(s) conducting behavioral management training PMAB, Regional Medical Director
☒ Employee code of conduct
☒ Medical Staffing: For all Hospitals, submit a letter from the chief of the medical staff or medical director of the hospital or facility, ensuring an adequate number of nurses, direct care staff, physicians, nurse practitioners or physician assistants shall be available at the hospital or facility, to provide emergency medical services. (including the availability of 24/7 medical supervision and at least one registered nurse on duty at all times, (see OAR 309-033-0725)
☒Copy of current hospital or non-hospital treatment facility license. **On file, onsite**
☒ Submit a copy of the current Quality Assurance Plan, as well as a copy of the restraint review committee meetings from the past year (if applicable) **Seclusion or Restraint QAP is included in the Seclusion or Restraint policy, page 12.**
☒ Submit an outline of the training curriculum with a copy of any changes or updates in the training curriculum from the last date of certification **(PMAB)**
☒ Submit documentation that the admission policies and procedures and **staff training for behavior management has been reviewed and approved by a psychiatrist or licensed psychiatric nurse** practitioner employed or under contract with the agency.
☒ Submit a copy of the legal warning given to individuals placed in custody under ORS 426.123
☐ If applicable, a copy of any MOU or agreement with a local community mental health program relating to the filing of NMI or coordination with the circuit court. N/A (THC only)
☒ Submit a new variance request for any current variance(s) to be renewed
FOR SECURE TRANSPORT HOSPITALS
~~☒ Submit a copy of the letter of support from the local community mental health program (CMHP), and any written agreement between the hospital and the regional acute care psychiatric program or the state hospital, based on the applicable OAR.~~
FOR NON-HOSPITAL FACILITIES (SRTF) CLASS I (Authorized to provide seclusion and restraint and administer medication without consent)
~~☒ Medical Staffing: Medical staffing. An adequate number of nurses, direct care staff, physicians, nurse practitioners or physician assistants shall be available at the hospital or facility, to provide emergency medical services which may be required. **For non-hospital facilities**, a written agreement with a local hospital, to provide such medical services may fulfill this requirement. When such an agreement is not possible, a written agreement with a local physician to provide such medical services may fulfill this requirement.~~
~~☐ A physician must be available 24 hours per day, seven days per week to provide medical supervision of the services provided~~
~~☐ At least one registered nurse must be on duty at all times.~~
~~☐ Submit documentation confirming that all Doors and windows have appropriate locks and alarms to maintain the security of the facility.~~

☐ ~~Copy of most recent fire marshal inspection~~
FOR NON-HOSPITAL FACILITIES (SRTF) CLASS II (not authorized to provide seclusion or restraint or provide medication without consent
☐ ~~Medical Staffing: Medical staffing. An adequate number of nurses, direct care staff, physicians, nurse practitioners or physician assistants shall be available at the hospital or facility, to provide emergency medical services which may be required. For non-hospital facilities, a written agreement with a local hospital, to provide such medical services may fulfill this requirement. When such an agreement is not possible, a written agreement with a local physician to provide such medical services may fulfill this requirement.~~
☐ ~~Submit a copy of a MOU or agreement with law enforcement agency for a response time within 15 minutes and to retake a person who has eloped and to return the person to the facility and to remove a person to an approved facility per policies.~~
☐ ~~Submit documentation of staffing pattern that maintains at least two qualified mental health associates are available 24 hours a day, seven days a week.~~
☐ ~~Submit documentation confirming that all Doors and windows have appropriate locks and alarms to maintain the security of the facility.~~
☐ ~~Copy of most recent fire marshal inspection~~
PART II: PROVIDER POLICIES (For all hospital and non-hospital facilities)
☒ Admission and assessment criteria- Regional Policies- **No changes to policies since time of last submission.**
☒ Involuntary custody procedures—**Updated NMI Policy attached**
☒ medical and emergency care procedures- **No changes to policies since time of last submission**
☒ Patient rights
☒ Seclusion and restraint- **No changes to policy since time of last submission**
☒ Administration of medication without consent **(Significant Procedures, under review)**
☒ Transfer and discharge of patients- **No changes to policies since time of last submission**
☒ Quality assurance review of seclusion and restraint incidents- **No changes to policy since time of last submission**
☒ The supervision and training of staff who may be involved with the administration or application of seclusion or restraint. **No changes to policy since time of last submission**
PART III, IV AND V FOR NEW APPLICATIONS ONLY
PART III: TRAINING CURRICULUM
☒ Submit a complete copy of training curriculum that includes all the required competencies identified in OAR 309-033-0720(3)(e)(A-J) https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=44911 **PMAB**
☒ Submit a letter describing the frequency of training for the management of endangering behaviors, and the credentialing of staff that provide the training. **PMAB**
PART IV: SAMPLE PERSONNEL RECORD—To be Completed During Onsite Review
☐ Verification of a criminal record check consistent with OAR 407-007-0000 through 407-007-0370
☐ A current job description(s) that includes applicable competencies;
☐ Copies of relevant licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications, including first aid and CPR training.

☐ Performance appraisal form
☐ Disciplinary documentation form/process
☐ Staff orientation documentation
☐ New hire training documentation
PART V: SAMPLE CLINCAL RECORD **To be Completed During Onsite Review** • Please do not submit Protected Health Information (PHI) • Only submit copies of blank templates to be used in practice • All documents required to fully reflect current service delivery OARs
The sample individual service record should include:
☐ Entry and orientation packet, to include all templates given to individuals upon entry, pursuant to program admission policies and procedures, including documentation or rights, consent to treatment, and complaint/grievance procedures.
☐ Documentation of Custody/Hold
☐ Documentation of legal warning and rights
☐ Mental Health Assessment
☐ Service/treatment Plan
☐ Discharge Plan
☐ Transfer Summary

SECTION VII: RESOURCES	
The following links may be useful resources as you prepare your application materials:	
Tools for Providers	http://www.oregon.gov/oha/amh/Pages/Tools-For-Providers.aspx
42 CFR, Part 2	http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs
ADA	http://www.ada.gov/
MOTS	http://www.oregon.gov/oha/amh/mots/pages/index.aspx
OR Trauma Policy	http://www.oregon.gov/oha/HSD/AMH/Trauma%20Policy/Trauma%20Policy.pdf
Drug Free Workplace Kit	http://www.samhsa.gov/sites/default/files/workplace-kit.pdf
Evidence-based Practices	http://www.oregon.gov/oha/amh/Pages/ebp.aspx
HIPAA	http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html
309-022 Rules	http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html
309-032 Rules	https://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_032.html
309-033 Rules	http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_033.html
309-035 Rules	https://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_035.html
309-039 Rules	http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_039.html
415-020 Rules	http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_415/415_020.html
415-057 Rules	http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_415/415_057.html